

Electronic Payment Authorization Form

Please type or print all entries.			
Coverage: Prime TR	(TRICARE Reserve Select)	☐ TRR (TRICARE Retired Reserve	e) TYA (TRICARE Young Adult)
Sponsor Name: Last	First	M.I.	Sponsor SSN or DBN
Home Address: Street	Apt. No.	City	State ZIP Code
Step 1: Choose the action you wish us to take.			
☐ START First Time Request ☐ CHANGE Request to Existing ☐ STOP Request to Existing ☐ (Complete Steps 2, 3 & 4 Below) ☐ (Complete Steps 2 & 4 Only) ☐ (Complete Step 4 only)			
Step 2: Select payment option to start or change and provide information requested.			
☐ Electronic Funds Transfer (EFT): Please start or change the automatic withdrawal of my monthly premiums/enrollment fees payable to UnitedHealthcare Military & Veterans by means of EFT from my financial institution.			
Please check one: ☐ Checking ☐ Savings Name of Financial Institution			
		ramo or r manolar n	
Name of Account Holder	9 Digit Ba	ank or ABA Routing Number	Account Number
□ Recurring Credit Card (RCC): Please start or change the automatic withdrawal of my monthly premiums/enrollment fees payable to UnitedHealthcare Military & Veterans by means of RCC from my financial institution. Please check one: □ Visa □ MasterCard □ Discover charges will appear as "UnitedHealthcare" on your credit card statement			
		<u> </u>	
Name of Card Holder	16 Digit C	redit Card Number	Expiration Date (MM/YYYY)
Step 3: Prepayment of 2 months premiums/enrollment fees due with the submission of your <u>START</u> request. Note: If effective date of the enrollment was not the first of the month, prorated premiums may also apply.			
☐ Pay by Check: I wish to pay the prepayment of two-month's premiums/enrollment fees by enclosed check payable to UnitedHealthcare.			
☐ Pay by Credit Card: I wish to pay the prepayment of two-month's premiums/enrollment fees by credit card indicated below.			
Check box: ☐ Visa ☐ Master	Card Discover	If credit card is the same as RCC, o	check this box and skip to Step 4
			/
Name of Card Holder	16 Digit C	redit Card Number	Expiration Date (MM/YYYY)
Step 4: Authorize this request with your signature and return by mail or fax.			
My signature authorizes UnitedHealthcare Military & Veterans to START, CHANGE or STOP my automated payments as indicated in STEP 1. Rates, as determined by TRICARE (<i>rates subject to change with 30-day notice – see www.tricare.mil/costs</i>), will be withdrawn on the first business day of each month using the payment option selected in Step 2 and the one-time prepayment of two-month's premium/enrollment fee payments ⁽¹⁾ if selected in Step 3. This authorization will remain in full force unless cancelled by me in writing, UnitedHealthcare or my financial institution. I understand a \$20 administrative fee will be assessed for any payments returned due to insufficient or unavailable funds.			
Authorized Signature (Re	equired):	Da	ate:
Mail this form to: UnitedHealth TRICARE We P.O. Box 105 Atlanta, GA 3	est Region Enrollment Depar 492	tment	s form to: 1-877-890-7297 OU FOR YOUR SERVICE!

Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as "official use only."